the Standard Statewide Flat Rate or Basic Rate is referred to as the Transition Period Basic Rate. Effective July 1, 1999, the Standard Statewide Flat Rate is referred to as the Post Transition Period Basic Rate. The Transition Period Basic Rate consists of a Direct Care component and Indirect Care component. The Post Transition Period Basic Rate is based on allowable costs.

1. Transition Period Basic Rate and Complex Medical Needs Add-on Rate.

   a. Direct Care Component of the Transition Period Basic Rate. The Direct Care Component is based on the Statements received by the Division by December 91, 1996, for fiscal reporting periods ending September 30, 1996, or earlier (reporting Year). The Division desk reviews or field audits the Statements and for each facility determines a total allowable direct care (Direct Compensation, Direct Care Supplies and Food) cost per diem, hereafter referred to as the Direct Care Cost. For each facility, its Direct Care Cost is inflated using the percentage increase determined as follows:

      A Direct Care Cost statewide weighted average is determined for the Base Year and compared to a Direct Care Cost statewide weighted average for the preceding fiscal period, resulting in a percentage increase in Direct Care Cost.

      This percentage increase is applied to each facility's fiscal year that ends in the 1997/99 biennium.

      For each facility's fiscal year ending during the 1997/99 biennium, its Direct Care Cost is limited to a Direct Care.

Ceiling calculated as follows:

The Direct Care Cost is inflated to reflect changes in the DRI Index from the mid-point of each facility's reporting period to the mid-point of the transition period beginning July 1, 1997. The Direct Care Cost as adjusted for DRI inflation for all facilities are then ranked and the 70th percentile (Direct Care Ceiling) determined.

The Direct Care Ceiling as determined is inflated to the mid-point of each facility's fiscal year that ends during the 1997/99 biennium. The inflation factor used in each case will be the projected change in the DRI Index for calendar year 1997.

b. The Indirect Care Component of the Transition Period Basic Rate. Effective July 1, 1997, the Indirect Care Component of the Transition Period Basic Rate is the Indirect Care Rate effective July 1, 1996 inflated to July 1, 1997 using the projected change in the USCPI between December, 1996 and December, 1997, and then adding 2 cents a resident day to comply with OBRA 1987. The Indirect Care Rate is a flat rate established as the statewide weighted average rate. The Indirect Care Rate was phased in over four years beginning with the fiscal period ending June 30, 1992, so that in the fifth year all nursing facilities would receive the same indirect rate. To calculate the Indirect Care Rate, the rates for Property, Administration and Other Support that each facility would have received under the system in effect on June 30, 1991, were calculated as if the system had continued

in existence, with one exception. For facilities with less than 95% occupancy rates, per resident day Administration and Other Support costs were adjusted to what they would have been at 95% occupancy; this adjustment was made by dividing allowable Administration and other Operating Support costs by the number of resident days facilities would have had if they had been 95 percent full during the relevant cost reporting period. These three rates were then combined to form the "base indirect rate" for each facility. To calculate the weighted average, the base indirect rate was multiplied by the facility Medicaid days. The sums of all of these calculations were added together and divided by total Medicaid days to arrive at the statewide weighted average. To establish July 1, 1993 rates, these adjusted 1991 rates were inflated by the one-year change in the National Nursing Home Market Basket as measured in the fourth quarter of 1991; plus thereafter, rates were inflated on July l by the change in the US CPI for the previous calendar year. For example, the Indirect Care Rate as of July 1, 1997 is inflated to July 1, 1998 using the projected change in the USCPI between December, 1996 and December, 1997. The statewide weighted average rate was not rebased. However, a statewide indirect add-on rate was computed to account for indirect costs previously included in direct cost accounts. The method for calculating the indirect add-on was as follows. Costs of inservice directors, central supply clerks and leased oxygen equipment appearing in the Statements used to set the indirect rates were identified and summed. For each facility, these costs were divided by the greater of the number of the resident days the nursing facility actually reported on the Statement used to set the 1991

rates, or the number of days the facility would have had at 95 percent occupancy. This calculation resulted in an add-on to the facility specific indirect rate. The statewide indirect add-on rate was computed by multiplying the facility specific rates by the number of Medicaid resident days for each facility. The sums of all these calculations were added together and divided by the total number of Medicaid days to arrive at the statewide weighted average.

The Indirect Care Rate was phased in over five years, from State Fiscal Year 1991-92 through State Fiscal Year 1995-96. Each year of the phase-in period, a larger share of the rate received by each facility is comprised of the statewide average (see following table).

Indirect Rate Phase-In

State Fiscal Year	% Facility Specific	% Statewide Average
1991-92	80%	20%
1992-93	60%	40%
1993-94	40%	60%
1994-95	20%	80%
1995-96	0%	100%.

The Indirect Care Rate was inflated each July 1 by the US CPI. During the phase-in period, facility specific rates were inflated by the same factor.

c. Initial Transition Period Weighted Average Rate. For each facility, its Direct Care Cost as adjusted for inflation and subject to the Direct Care Ceiling is combined with the Indirect Care Rate resulting in a facility specific weighted average rates. A statewide

weighted average rate (the Initial Transition Period Weighted Average Rate) is then determined by applying each facility's specific weighted average rate against its total number of patient days in its Base Year.

d. Initial Transition Period Base Pool. The Initial Transition Period Weighted Average Rate is next applied to the projected caseload for the 1997/99 biennium to arrive at the Initial Transition Period Base Pool.

The number of clients in pediatric nursing facilities or in self-contained pediatric nursing units as of December 31, 1996, are then determined and the total number of clients is multiplied by the pediatric rate determined in II.C. as adjusted for inflation using the DRI. The resulting amount is subtracted from the Initial Transition Period Base Pool resulting in an Initial Transition Period Base Pool excluding pediatric costs.

e. Complex Medical Needs Add-on. The Initial Transition Period Base Pool after removal of pediatric costs is divided by the projected caseload for the 1997/99 biennium less the number of clients in pediatric nursing facilities or in self-contained pediatric nursing units as of December 31, 1996, resulting in an Initial Transition Period Non-Pediatric Basic Rate. Forty percent (40%) of this rate is the Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on Rate is applied to the number of clients in facilities who met the Complex Medical Needs Add-on criteria (II.B.) in June 1997. The resulting amount is then subtracted from the Initial Transition Period Base Pool after removal of pediatric costs resulting in an Initial Transition Period Base Pool after the removal of pediatric costs and Complex Medical Needs Add-on costs.

f. Transition Period Basic Rate. The Initial Transition Period Base Pool after removal of pediatric and Complex Medical Needs Add-on costs is then divided by the projected caseload for the 1997/99 biennium, less the pediatric caseload (number of clients in pediatric nursing facilities or in self-contained pediatric nursing units as of December 31, 1996) and the Complex Medical Needs Add-on caseload (the number of clients in facilities who meet the Complex Medical Needs Add-on criteria in June 1997), resulting in the Transition Period Basic Rate.

The Division determines as of November 30, 1997, May 31, 1998, and November 30, 1998, the number of clients in each facility on whose behalf payments are made at the Transition Period Basic Rate and the number of clients subject to the Complex Medical Needs Add-on Rate. Deviations in the pediatric caseload (number of clients in pediatric nursing facilities or in self-contained pediatric nursing units as of December 31, 1996) and Complex Medical Needs Add-on caseload (the number of clients in facilities who meet the Medical Add-on criteria in June 1997) will result in the Transition Period Basic Rate being adjusted to ensure that the Initial Transition Period Base Pool remains constant. The recalculated Transition Period Basic Rate becomes effective on the first day of the second calendar month following the date of the recalculation. The Transition Period Basic Rate effective July 1, 1998, is based on the Transition Period Basic Rate recalculated on May 31, 1998 and adjusted for inflation using the DRI.

2. Post Transition Period Basic Rate and Complex Medical Needs Add-on Rate.

a. Initial Post Transition Period Basic Rate. For the first year of each biennium (the Rebasing Year), the Post Transition Period Basic Rate is based on the Statements received by the Division by September (or postmarked by October 31, if an extension of filing has been approved by the Division) for the fiscal reporting period ending on June 30 of the previous even-numbered year, e.g., for the biennium beginning July 1, 1999, Statements for the period ending June 30, 1998 are used. Statements for pediatric nursing facilities are not used to determine the Post Transition Period Basic Rate. The Division desk reviews or field audits these Statements and determines for each nursing facility, its allowable costs less the costs of its self-contained pediatric unit, if any.

For each facility, its allowable costs, less the costs of its self-contained pediatric unit (if any) is inflated from the mid-point of its fiscal reporting period to the mid-point of the first year of the biennium, hereafter referred to as the Post Transition Period Base Year (e.g., for the biennium beginning July 1, 1999, the Post Transition Period Base Year is the fiscal period ending June 30, 2000) by projected changes in the DRI Index.

For each facility, its Allowable Costs Per Medicaid Day is determined using the allowable costs as inflated and resident days excluding days in a self-contained pediatric unit as reported in the Statement.

A Statewide Weighted Average Allowable Costs Per Medicaid Day (the Initial Post Transition Period Basic Rate) is determined by applying the Allowable Costs Per Medicaid Day for each facility to its total Medicaid days excluding days in a self-contained pediatric unit as reported in the Statement, summing the computations for all applicable facilities, and dividing the results by the total resident days (excluding total days in self-contained pediatric units) for all facilities.

b. Post Transition Period Basic Rate for the period July 1, 1999 through June 30, 2003. The relationship that the Transition Period Basic Rate effective July 1, 1997 bears to the Initial Transition Period Weighted Average Rate (excluding pediatric facilities and self-contained pediatric units) is determined. The resulting percentage (Benchmark) is used to determine the Post Transition Period Basic Rate for the first year of the biennium. The Benchmark is applied to the Initial Post Transition Period Basic Rate to determine the Post Transition Period Basic Rate for the first year of the biennium.

The Post Transition Period Basic Rate for the second year (Non-Rebasing Year) of the biennium is the Post Transition Period Basic Rate for the first year, inflated by the DRI Index.

c. Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on Rate is 40 percent of the Post Transition Period Basic Rate.

d. Rebasing Year Adjustment. In a Rebasing Year in which the Post Transition Period Basic Rate is less than the Post

Transition Period Basic Rate in the prior Rebasing Year adjusted for inflation using the DRI, the Post Transition Period Basic Rate for the new Rebasing year will be increased by one-half the difference between the two rates.

3. For the period beginning July 1, 2003 through June 30, 2005, new Basic Rates are computed by eliminating the Benchmark and replacing it with the 63rd percentile of allowable costs (both direct and indirect).

4. For the period beginning July 1, 2005 through June 30, 2007, the Benchmark is eliminated and replaced with the 70th percentile of allowable costs (both direct and indirect).

5. The Basic Rate established in steps B.3. and B.4. above is inflated by the DRI Index in the second year (the Non-Rebasing Year).

6. Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on Rate is 40 percent of the Basic Rate.

C. Pediatric Nursing Facilities.

1. Pediatric nursing facility means a licensed nursing facility, 50% of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21.

2. Pediatric nursing facilities will be paid a per diem rate of $188.87 commencing on August 1, 1999, which rate will:

a. Be prospective;

b. Not be subject to settlement; and

c. The per diem rate will be calculated as follows:

The per resident day total cost from the desk reviewed or the field audited cost report for all pediatric nursing facilities are summed and divided by the total pediatric resident days. The base year will be 1998. Once the weighted average cost is determined, the rebase relationship percentage (90.18%), determined in the implementation of the flat rate system in 1997, is applied to set the new rate. Before computing the weighted average cost, the facility-specific total costs are inflated by a change in the DRI Index to bring the cost to the rebase year.

On July 1 of each non-rebase year after 1999, the pediatric rate will be increased by the annual change in the DRI Index, as measured in the previous 4th quarter. Beginning in 2001 rate setting will occur in alternate years. Rebasing of pediatric nursing facility rates will be calculated using the method described above.

3. Pediatric nursing facilities must comply with all requirements relating to timely submission of Nursing Facility Financial Statements.

D. Licensed Nursing Facility With a Self-Contained Pediatric Unit.

1. A nursing facility with a self-contained pediatric unit means a licensed nursing facility that cares for pediatric residents (residents under the age of 21) in a separate and distinct unit within or attached to the facility.

2. Nursing facilities with a self-contained pediatric unit will be paid in accordance with subsection C.2. of this section for pediatric residents cared for in the pediatric unit.

3. Nursing facilities with a self-contained pediatric unit must comply with all requirements related to timely submission of Nursing Facility Financial Statements and must file a separate attachment, on forms prescribed by the Division, related to the costs of the self-contained pediatric unit.

IV. Public Process

The State has in place a public process which complies with the requirement of Section 1902(a)(13)(A) of the Social Security Act.

V. 2003 State Legislative Changes (change in the definition of allowable costs.)

a. Nursing Facility Assessments. The nursing facility assessment is an allowable Medicaid cost.